Immunization Entry Requirements for Schools, Preschools and Child Care Facilities ✂

Vaccines are listed under the routinely recommended ages. Shaded bars indicate range of acceptable ages for vaccination.

Age → / Vaccine ↓	Birth	2 Months	4 Months	6 Months	12 Months	15 Months	18 Months	4-6 Years	11-12 Years	14-16 Years
Hepatitis B **	Hep B-1									
		Hep B-2		Hep B-3						
Diphtheria, Tetanus, Pertussis		DTP	DTP	DTP	DTP or DTaP at 15+ Mo			DTP or DTaP	Td **	
H. Influenzae type b		Hib	Hib	Hib	Hib					
Polio		Polio	Polio	Polio				Polio		
Measles, Mumps, Rubella					MMR			MMR	or MMR	

✂The above schedule was recommended and approved January 1, 1995 by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics and the American Academy of Family Physicians. Footnotes of this schedule provide more information about vaccines and when they can be given. They are reprinted in the Immunization Manual for Schools, Preschools and Child Care Facilities, which can be found at most schools and Local Health Departments. Although there are more medically current recommended schedules, the January 1995 schedule is the only one required by Washington State Immunization Law.

** Effective September, 1997

Statement of Exemption to Immunization Law

NOTICE:

Your Child can be exempted (excused) from immunization for medical, personal or religious reasons. However, if there is an outbreak of a vaccine-preventable disease that your child has not been immunized against, she or he can be excluded from school, preschool or child care until the outbreak is over.

☐ Medical Exemption

I certify that the child named on this form is medically exempted from the requirement for the following vaccine(s):

_____ Until _____

Vaccine(s) Date

_____

Type or Print Physician's name Date

_____

Physician's Signature

☐ Personal Exemption
☐ Religious Exemption

I am opposed to immunization. I understand that my child can be excluded from attendance during an outbreak

I do not want my child to receive the following vaccine(s):

_____

Vaccine(s)

_____

Signature of Parent or Guardian Date

Documentation of Immunity

I certify that the child named on this form has laboratory evidence of immunity to measles/mumps/rubella (please circle).

Attach TITER results

_____

TYPE or PRINT Physcian's Name

_____

Physician's Signature or Stamp Date